Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VALLEY REGIONAL MEDICAL CENTER
3701 KIRBY DRIVE STE 1288
HOUSTON TX 77098-3926

Respondent Name
WESLACO ISD

Carrier's Austin Representative Box
#29

MFDR Tracking Number
M4-10-0245-01

MFDR Date Received
SEPTEMBER 14, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…it is the position of the Provider that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the carrier in this case…"

Amount in Dispute: $9,680.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "carrier has paid correctly per contract"

Response Submitted by: Pappas & Suchma, PC, P. O. Box 66655, Austin, TX 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 10, 2008 Through October 12, 2008	Inpatient Hospital Surgical Services	$9,680.61	$708.84

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 22, 2008

- 222 — Charge exceeds Fee Schedule allowance
- 380 — Recommendation is based on attached invoice
- 993 — Reduction is based on the Inpatient Fee Schedule.
- ANSIW1 — Workers Compensation State Fee Schedule Adjustment.
- EPFH — A First Health owned PPO network contract discount was applied. For PPO contract questions, please call (800) 937-6824.

Explanation of benefits dated June 30, 2009

- 222 — Charge exceeds Fee Schedule allowance
- 380 — Recommendation is based on attached invoice
- ANSI193 — Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- ANSI145 — 45 — Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- ANSIW1 — W1 —Workers Compensation State Fee Schedule Adjustment.
- ANSIW3 — W3 —Additional payment made on appeal/reconsideration.
- P32 — A First Health/Focus/Healthcare Mgmt., Inc. PPO contract discount was applied. For PPO contract questions, please call (800) 243-2336.
- P99 — PPO Reductions based on client negotiated agreement

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the facility request separate reimbursement for implantables?
3. Did the facility support its request for separate reimbursement for the implantables?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. On October 7, 2010, the division requested a copy of the written notification to the health care provider pursuant to 28 TAC §133.4. Although some contract information was provided by the carrier, no documentation was provided to support that the carrier and respondent in this dispute **notified** the health care provider as required by rule §133.4. Specifically, the carrier failed to support that notice containing the information stated in paragraphs (d)(1), (2)(A) and (2)(B) was made; and it failed to support that that the notice was made timely pursuant to section (f).The division concludes: (1) that the carrier is not entitled to pay the requestor at a contracted fee pursuant to 28 TAC 133.4 (g); and (2) that the division fee guidelines apply pursuant to 28 TAC 133.4 (h).
2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless
   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   Review of the documentation finds that that the facility requested separate reimbursement for implantables; for that reason, the requirements of subsection (g) apply.

3. §134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

(1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

Review of the documentation found supports that the following items were certified as required by (g):

Itemized Statement Rev Code or Charge Code	Itemized Statement Description	Cost Invoice Description	# Units & Cost Per Unit	Cost Invoice Amount	***Per item*** Add-on (cost +10% or $1,000 whichever is less).
278	1 JNT DV HD HMRL 43X16	AEQ HUMERAL HEAD 43 X 16	1 at $1,888.00 ea	$1,888.00	$2,076.80
278	1 JNT DV RSTRCT CEM EB01	CEMENT RESTRICTOR	1 at $168.00 ea	$168.00	$184.80
278	1 JNT DEV HUMERAL STEM 2	AEQ STEM FOR FRACTURE 6.5 X 130MM HA COATED	1 at $4,274.00 ea	$4,274.00	$4,701.40
				$6,330.00	$6,963.00
				Total Supported Cost	**Sum of Per-Item Add-on**

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

4. §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, ***plus*** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at http://www.cms.gov, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

   - Documentation found supports that the DRG assigned to the services in dispute is DRG 484, and that the services were provided at Valley Regional Medical Center. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $13,772.55. This amount multiplied by 108% results in an allowable of $14,874.35.
   - The total cost for implantables from the table above is $6,330.00. The sum of the per-billed-item add-ons does not exceed the $2000 allowed by rule; for that reason, total allowable amount for implantables is $6,330.00 plus 10% ($633.00), which equals $6,963.00.

   Therefore, the total allowable reimbursement for the services in dispute is $14,874.35 plus $6,963.00, which equals $21,837.35. The respondent issued payment in the amount of $21,128.51. Based upon the documentation submitted additional reimbursement in the amount of $708.84 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $708.84 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 21, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.